Case studies in population health management

Southwestern Health Resources, the largest provider network in North Texas, is a national leader in population-based healthcare. 

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Shared Decision-Making for Colorectal Cancer Screening

Project improves care gap closure in 90 days

Participating clinics exceed original target goal of 25% by strengthening the patient-provider relationship and communication.

11 clinics achieved a gap closure rate of 32%, exceeding the original goal of 25%.

“This project is a team effort that means a lot because we’re helping vulnerable people.”
—Connie Gamez, Practice Administrator, Texas Health Family Care

The Problem

Colorectal cancer (CRC) is the second-leading cause of cancer deaths in the U.S. for men and women. Often silent in the beginning, CRC is highly curable if caught early, with a five-year relative survival rate of approximately 90% — and yet just one in three adults who meet the criteria are screened for CRC. In addition, CRC screening isn’t a subject that patients tend to bring up with providers, putting the onus on providers to draw attention to the issue. That was the reasoning behind a 2019 Southwestern Health Resources (SWHR) pilot project.

The Solution

SWHR launched the CRC screening shared decision-making project because colorectal cancer prevention is a pillar in its overall approach to population health management. The project set a goal to achieve a gap closure rate of 25% over a defined three-month period. As a national leader in population health, SWHR works to support physicians with the latest technology, data and resources to help them optimize results for patients and achieve better overall efficiency. Increased CRC screening means that cancer is caught earlier, improving outcomes and decreasing the cost of care.
Going beyond contracted quality measures is a hallmark of SWHR’s approach to population management. “We want colorectal screening ordered during their visit for any patient with a screening gap, regardless of why they’re here,” said Ashnia Taher, MHA, CSSGB, Specialist Lean Six Sigma Process Improvement and pilot project leader for SWHR. “Our view is that when patients are in the office, there are opportunities to close care gaps.”

“We realize how much our physicians want to help their patients stay healthy today and in the long term, but we also understand how busy our physicians are,” said Jason Fish, MD, SVP and Chief Medical Officer for SWHR. “So we created this project to help close CRC screening gaps with both of those issues in mind.”

Eleven clinics within Texas Health Physicians Group (THPG) in the SWHR network took part in the pilot project. Community physicians and staff were trained on the impact of screening and available screening options via on-site educational sessions. The objective was clear: get the unscreened patients screened.

THREE STEPS TO CLOSE THE GAP

SWHR created a three-step process to support the practices in their efforts to close patient screening gaps:

1. IDENTIFY TARGET PATIENTS

To save the practices valuable time and show them specifically where to focus their efforts, SWHR submitted to each clinic semi-monthly lists of patients ages 50 to 75 who were scheduled to visit the clinic within the next two weeks and needed a screening. Clinics were also encouraged to check for screening care gaps with walk-in patients whose names didn’t appear on these lists.

These patient lists have already proved their value, according to Lana Riddle, practice manager for Jose Ceja, MD. “The lists allowed me to inform Dr. Ceja day by day who he needed to speak with about testing,” she said.

“To be patient-centered and physician-centered, you need underlying strong data. The better data you have, the better you are at providing reliable, usable actionable information to the medical community.”

—Jason Fish, MD, SVP and Chief Medical Officer, SWHR

2. INTRODUCE THE COLORECTAL SHARED DECISION-MAKING TOOL

SWHR designed its Colorectal Cancer Screening Shared Decision-Making Tool to inform patients by:

• Defining colorectal cancer and emphasizing the importance of early screening
• Clearly explaining all screening options
• Providing specific guidance and talking points to encourage open patient-provider communication, resulting in the best screening decision for the patient
• Further strengthening the patient-provider relationship by providing a road map for a conversation that some patients might find uncomfortable
The CRC Shared Decision-Making Tool supports productive and comfortable conversations between patients and their providers. “When the physician hands the patient the tool, they explain the rationale and reasoning behind the need for screening and what kind of screening might be best for them, based on their needs and medical history,” said Connie Gamez, Practice Administrator at Texas Health Family Care locations Jerome and Southwest.

“I see it as a positive tool that’s useful for both the patient and the practice.”
— Jose Ceja, MD, Texas Health Family Care Clinic

“Our clinic saw positive results, and most patients were open to discussing and hearing more. It allows the patient and provider to make an informed decision regarding the type of screening to order during the visit,” said Jose Ceja, MD, Texas Health Family Care Clinic.

The tool also allows providers to discuss and address barriers to patient screening as they arise, including insurance coverage for testing. In addition, patients may not have anyone to drive them home from a colonoscopy, or they may not want to undergo the cleansing process a colonoscopy requires. Others who will not consider a colonoscopy may be open to a less invasive test they can do in the privacy of their homes.

For patients unwilling to commit to screening during their visit, the tool serves as a take-home reminder on the importance of CRC screening. “When Dr. Ceja discusses options with patients, that plants the seed,” Riddle said. “Then maybe later they’ll pick up the document at home and reconsider the importance of testing.”

IMPLEMENT A TRACKING AND FOLLOW-UP PROCESS

A tracking system and patient follow-up process helps clinic staff members determine which patients have not been screened so that they can follow up. Gamez and her staff make the most of this opportunity to show patients how much they matter.

“We say to the patient, ‘We noticed that you’re overdue for CRC screening, and it’s so important to catch this cancer early because it exhibits very few if any symptoms until it’s too late. That’s why your physician really wants you to get screened,’” Gamez said.

Results exceed the target

During the three-month pilot project screening phase (August, September and October 2019), the 11 clinics achieved a gap closure rate of 32% — exceeding the original goal of 25%. This means that of the 1,500 patient names provided, clinics closed nearly 500 CRC screening care gaps (including both patients who completed screening during the process and those who completed screening prior to the pilot).

“The pilot project was definitely a benefit to our practice,” Ceja said. “Not only did we see an increase in the quality measure, but patient awareness on the importance of CRC screening and early detection also increased.”

Patient awareness increased on the importance of CRC screening and early detection.
Texas Health Family Care Clinic began the pilot in August with a baseline colorectal cancer screening performance rate of 4.78%. Within three months, that number increased to 24%. Even though those numbers do include some patients who were previously tested, Riddle said that she, Ceja and the clinic staff are thrilled with the results because they know they’re saving lives.

“This was a good thing for both us and our patients — and the numbers prove it,” Riddle said. “We continue to identify patients who need the screening, and we’re continuing on with the tool and education, and we’re seeing a steady increase in screening as a result.”

**Sources**
